		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013896

Facility Name: St. Matthew Center for Health

Address: 1601 N. Western Ave (Number) Park Ridge, Illinois (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 825-5531 **Fax #** (847) 318 - 6659

IDPA ID Number: 36-2584799 - 001

Date of Initial License for Current Owners: 1959

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501 (C) (3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Sonia Channa **Telephone Number:** (847) 390 - 1411

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2003 to 06/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 176

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	56	Intermediate (ICF)	56	20,496	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,416	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		22,341	5,802	28,143	8
9	SNF/PED					9
10	ICF	13,380			13,380	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,380	22,341	5,802	41,523	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.46%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N / A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N / A]

I. On what date did you start providing long term care at this location?
Date started 1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5,802

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2004 Fiscal Year: 06/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	321,853	31,195	98,734	451,782		451,782		451,782			1
2	Food Purchase		226,238		226,238		226,238	1,732	227,970			2
3	Housekeeping	106,084	24,301		130,385		130,385		130,385			3
4	Laundry	52,676	1,758	71,168	125,602		125,602		125,602			4
5	Heat and Other Utilities			123,693	123,693	2,755	126,448		126,448			5
6	Maintenance	109,637	8,523	113,844	232,004	10,361	242,365		242,365			6
7	Other (specify):* Rubish removal			16,760	16,760	993	17,753		17,753			7
8	**TOTAL General Services**	590,250	292,015	424,199	1,306,464	14,109	1,320,573	1,732	1,322,305			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	2,750,303	367,055	26,122	3,143,480		3,143,480		3,143,480			10
10a	Therapy	24,893		612,547	637,440		637,440		637,440			10a
11	Activities	78,115	3,396	7,542	89,053		89,053		89,053			11
12	Social Services	117,366		7,717	125,083		125,083		125,083			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Dentist											15
16	**TOTAL Health Care and Programs**	2,970,677	370,451	670,428	4,011,556		4,011,556		4,011,556			16
	C. General Administration											
17	Administrative	61,096			61,096	291,884	352,980		352,980			17
18	Directors Fees											18
19	Professional Services			714,611	714,611	(511,185)	203,426	(703)	202,723			19
20	Dues, Fees, Subscriptions & Promotions			40,181	40,181	4,301	44,482		44,482			20
21	Clerical & General Office Expenses	239,469	43,016	57,964	340,449	26,475	366,924		366,924			21
22	Employee Benefits & Payroll Taxes			974,248	974,248	71,885	1,046,133		1,046,133			22
23	Inservice Training & Education					4,209	4,209		4,209			23
24	Travel and Seminar			7,668	7,668		7,668		7,668			24
25	Other Admin. Staff Transportation					6,260	6,260		6,260			25
26	Insurance-Prop.Liab.Malpractice			277,810	277,810	14,183	291,993		291,993			26
27	Other (specify):* Fundraising					37	37	(37)				27
28	**TOTAL General Administration**	300,565	43,016	2,072,482	2,416,063	(91,951)	2,324,112	(740)	2,323,372			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,861,492	705,482	3,167,109	7,734,083	(77,842)	7,656,241	992	7,657,233			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St. Matthew Center for Health #0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			395,322	395,322	40,101	435,423	6,139	441,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			199,716	199,716	8,201	207,917	(11)	207,906			32
33	Real Estate Taxes					171	171		171			33
34	Rent-Facility & Grounds					27,414	27,414		27,414			34
35	Rent-Equipment & Vehicles			28,060	28,060	1,955	30,015		30,015			35
36	Other (specify):*											36
37	**TOTAL Ownership**			623,098	623,098	77,842	700,940	6,128	707,068			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,361	96,361		96,361		96,361			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			96,361	96,361		96,361		96,361			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,861,492	705,482	3,886,568	8,453,542		8,453,542	7,120	8,460,662			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	1,732	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,731	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,332)	9,27,30		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 7,120		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 7,120		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

St. Matthew Center for Health

ID# 0013896

Report Period Beginning: 07/01/2003

Ending: 06/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable Mgmt & HR Allocation	$ (702)	19	1
2	Allowable Serv. Network Allocation	(1)	19	2
3	Management Auto Depreciation	(274)	30	3
4	Non-program auto depreciation	(2,318)	30	4
5	Adjust in Advertising & Promotions- Mgmt	88	27	5
6	Adjust out Advertising & Promotions-Serv Network	(125)	27	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,332)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St. Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	1,732	0	0	0	0	0	0	0	0	0	0	1,732	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,732	0	0	0	0	0	0	0	0	0	0	1,732	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(703)	0	0	0	0	0	0	0	0	0	0	(703)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(37)	0	0	0	0	0	0	0	0	0	0	(37)	27
28	**TOTAL General Administration**	(740)	0	0	0	0	0	0	0	0	0	0	(740)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	992	0	0	0	0	0	0	0	0	0	0	992	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St. Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,139	0	0	0	0	0	0	0	0	0	0	6,139	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11)	0	0	0	0	0	0	0	0	0	0	(11)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	6,128	0	0	0	0	0	0	0	0	0	0	6,128	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,120	0	0	0	0	0	0	0	0	0	0	7,120	45

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A	N/A	Vesper Mgmt Corp	Des Plaines Illinois	Mgmt co.
				LSSI	Des Plaines Illinois	Corp. Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		N/A	$	N/A		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	29,215,047	265	$ 1,898,520	$ 1,898,520	2,340,781	$ 152,114	1
2	22	Empl Benefits & Taxes		29,215,047	265	358,198		2,340,781	28,700	2
3	19	Prof Fees & Contract		29,215,047	265	1,831,337		2,340,781	146,731	3
4	21	Supplies, Telephone		29,215,047	265	196,737		2,340,781	15,763	4
5		Postage, Out. Printing		29,215,047	265	0		2,340,781	0	5
6	34	Rental of Space		29,215,047	265	338,143		2,340,781	27,093	6
7	5	Utilities		29,215,047	265	34,385		2,340,781	2,755	7
8	6	Bldg Repairs & Maintenance		29,215,047	265	920		2,340,781	74	8
9	32	Interest		29,215,047	265	102,362		2,340,781	8,201	9
10	33	Real Estate Taxes		29,215,047	265	2,136		2,340,781	171	10
11	26	Insurance		29,215,047	265	169,087		2,340,781	13,548	11
12	27	Advertising & Promotions		29,215,047	265	(1,103)		2,340,781	(88)	12
13	25	Transportation		29,215,047	265	41,676		2,340,781	3,339	13
14	35	Car Rental		29,215,047	265	418		2,340,781	33	14
15	23	Conferences & Conventions		29,215,047	265	38,609		2,340,781	3,093	15
16	20	Subscriptions, Dues, Awards		29,215,047	265	14,089		2,340,781	1,129	16
17	21	Furniture & Fixtures		29,215,047	265	3,080		2,340,781	247	17
18	6	Machinery & Equipment		29,215,047	265	(6)		2,340,781	0	18
19	35	Equipment Rental		29,215,047	265	8,348		2,340,781	669	19
20	6	Equipment Repair & Maint		29,215,047	265	116,469		2,340,781	9,332	20
21	20	Employee Recruitment		29,215,047	265	(1,054)		2,340,781	(84)	21
22	7	Security & Waste Removal		29,215,047	265	12,399		2,340,781	993	22
23	21	All Other Miscellaneous		29,215,047	265	36,656		2,340,781	2,937	23
24	30	Depreciation		29,215,047	265	484,253		2,340,781	38,800	24
25	TOTALS					$ 5,685,659	$ 1,898,520		$ 455,550	25

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	45,669,555	250	$ 764,920	$ 764,920	4,835,805	$ 80,995	1
2	22	Empl Benefits & Taxes		45,669,555	250	165,686		4,835,805	17,544	2
3	19	Prof Fees & Contract		45,669,555	250	159,313		4,835,805	16,869	3
4	21	Supplies, Telephone		45,669,555	250	45,527		4,835,805	4,821	4
5		Postage, Out. Printing		45,669,555	250			4,835,805		5
6	34	Rental of Space		45,669,555	250	2,789		4,835,805	295	6
7	5	Utilities		45,669,555	250			4,835,805		7
8	6	Bldg Repairs & Maintenance		45,669,555	250	16		4,835,805	2	8
9	32	Interest		45,669,555	250			4,835,805		9
10	33	Real Estate Taxes		45,669,555	250			4,835,805		10
11	26	Insurance		45,669,555	250	3,482		4,835,805	369	11
12	27	Advertising & Promotions		45,669,555	250			4,835,805		12
13	25	Transportation		45,669,555	250	9,361		4,835,805	991	13
14	35	Car Rental		45,669,555	250	488		4,835,805	52	14
15	23	Conferences & Conventions		45,669,555	250	6,764		4,835,805	716	15
16	20	Subscriptions, Dues, Awards		45,669,555	250	4,313		4,835,805	457	16
17	21	Furniture & Fixtures		45,669,555	250			4,835,805		17
18	6	Machinery & Equipment		45,669,555	250			4,835,805		18
19	35	Equipment Rental		45,669,555	250	9,350		4,835,805	990	19
20	6	Equipment Repair & Maint		45,669,555	250	1,647		4,835,805	174	20
21	20	Employee Recruitment		45,669,555	250	25,418		4,835,805	2,691	21
22	7	Security & Waste Removal		45,669,555	250			4,835,805		22
23	21	All Other Miscellaneous		45,669,555	250	4,840		4,835,805	512	23
24	30	Depreciation		45,669,555	250	6,910		4,835,805	732	24
25	TOTALS					$ 1,210,824	$ 764,920		$ 128,210	25

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 6/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave. Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non Capital Direct Costs	5,427,946	2	$ 136,290	$ 136,290	2,340,781	$ 58,775	1
2	22	Empl Benefits & Taxes		5,427,946	2	59,458		2,340,781	25,641	2
3	19	Prof Fees & Contract		5,427,946	2	15,207		2,340,781	6,558	3
4	21	Supplies, Telephone		5,427,946	2	4,618		2,340,781	1,991	4
5		Postage, Out. Printing		5,427,946	2			2,340,781		5
6	34	Rental of Space		5,427,946	2	60		2,340,781	26	6
7	5	Utilities		5,427,946	2			2,340,781		7
8	6	Bldg Repairs & Maintenance		5,427,946	2			2,340,781		8
9	32	Interest		5,427,946	2			2,340,781		9
10	33	Real Estate Taxes		5,427,946	2			2,340,781		10
11	26	Insurance		5,427,946	2	616		2,340,781	266	11
12	27	Advertising & Promotions		5,427,946	2	291		2,340,781	125	12
13	25	Transportation		5,427,946	2	4,476		2,340,781	1,930	13
14	35	Car Rental		5,427,946	2			2,340,781		14
15	23	Conferences & Conventions		5,427,946	2	928		2,340,781	400	15
16	20	Subscriptions, Dues, Awards		5,427,946	2	250		2,340,781	108	16
17	21	Furniture & Fixtures		5,427,946	2			2,340,781		17
18	6	Machinery & Equipment		5,427,946	2			2,340,781		18
19	35	Equipment Rental		5,427,946	2	490		2,340,781	211	19
20	6	Equipment Repair & Maint		5,427,946	2	1,807		2,340,781	779	20
21	20	Employee Recruitment		5,427,946	2			2,340,781		21
22	7	Security & Waste Removal		5,427,946	2			2,340,781		22
23	21	All Other Miscellaneous		5,427,946	2	472		2,340,781	204	23
24	30	Depreciation		5,427,946	2	1,319		2,340,781	569	24
25	TOTALS					$ 226,282	$ 136,290		$ 97,583	25

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tax Exempt Bonds		X	Refinance Building Additions	N/A	9/23/93	$ 1,286,188	$ 2,710,020	8/15/20	0.0738	$ 199,716	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Allocation		X	Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	8,201	6
7												7
8												8
9	TOTAL Facility Related						$ 1,286,188	$ 2,710,020			$ 207,917	9
	B. Non-Facility Related*											
10	Interest Income			Offset against Interest expense	N/A	N/A	N/A	N/A	N/A	N/A	(11)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (11)	14
15	TOTALS (line 9+line14)						$ 1,286,188	$ 2,710,020			$ 207,906	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St. Matthew Center for Health COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0013896

CONTACT PERSON REGARDING THIS REPORT Sonia Channa

TELEPHONE 847 390-1411 FAX #: 847 635-6764

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ N/A	$ N/A

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,590 B. General Construction Type: Exterior Masonry Frame Steel Grids Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,354	1958	$ 38,704	1
2					2
3	TOTALS	203,354		$ 38,704	3

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066	7,877	40	7,877		303,083	5
6			1976	1976	2,205,040	55,126	40	55,126		1,570,871	6
7			1976	1976	24,547	614	40	614		17,196	7
8			1977	1977	13,438	336	40	336		9,237	8
	Improvement Type**										
9	1983 Addition			1983	150,179		10			150,179	9
10	1978 Addition			1978	1,780		10			1,780	10
11	1979 Addition			1979	5,380		10			5,380	11
12	1983 Addition			1983	2,142		10			2,142	12
13	1984 Addition			1984	11,139		10			11,139	13
14	1985 Addition			1985	2,400		10			2,400	14
15	1986 Addition			1986	7,692		10			7,692	15
16	1987 Addition			1987	291,787	11,671	25	11,671		240,344	16
17	Renovations			1989	268,451		10			268,451	17
18	ADJUSTMENT PER IDPA - 1989 Renovations			1989	(22,714)		10			(22,714)	18
19	ADJUSTMENT PER IDPA - 1988 Costs			1988	14,914		10			14,914	19
20	Canopy / Western ave.			1992	30,720	1,229	25	1,229		15,373	20
21	Panasonic Camera System			1992	3,720		5			3,720	21
22	New Sidewalk			1992	2,500		10			2,500	22
23	Concrete Loading dock			1992	6,690		10			6,690	23
24	Bathroom Remodeling			1992	13,440		10			13,440	24
25	Chapel Renovation			1992	33,385		10			33,385	25
26	Generator & Mechanical Work			1993	43,564	2,054	10	2,054		43,564	26
27	New Roof West Building			1993	208,807	9,845	10	9,845		208,807	27
28	Generator Projct & electrical			1993	146,296	6,898	10	6,898		146,296	28
29	Upgrade West Building Electrical			1993	19,029	897	10	897		19,029	29
30	Alzeheimer Unit			1992	40,114	1,891	10	1,891		40,114	30
31	Alzeheimer Unit			1993	35,728	1,685	10	1,685		35,728	31
32	ADJUSTMENT PER IDPA - Alzeheimer Unit			1993	(6,025)		10			(6,025)	32
33	ADJUSTMENT PER IDPA - 1990 Improvements OHF			1990	19,450		10			19,450	33
34	Parking Lot Lighting			1994	17,300	817	10	817		17,300	34
35	Shower Room Renovation			1994	9,455	945	10	945		9,014	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Rehab Area Renovation	1994	$ 55,583	$ 5,558	10	$ 5,558	$	$ 52,991	37
38	Air Conditioning - West Bldg	1995	32,823	3,282	10	3,282		30,221	38
39	Air Conditioning Project - #95-056	1995	5,423	542	10	542		4,633	39
40	ADA Elevator Upgrade	1996	5,548	555	10	555		4,730	40
41	Air Conditioner - Laundry Room	1997	842	84	10	84		567	41
42	Fence & Installation	1997	674	67	10	67		454	42
43	Kitchen A/C & Installation	1997	17,500	1,750	10	1,750		14,151	43
44	Installation of Fire Doors	1997	4,897	196	25	196		1,289	44
45	Landscape Materials	1998	1,600	160	10	160		985	45
46	Retainers - Int. Design	1998	3,085	308	10	308		1,847	46
47	Interior Design Fees	1998	1,349	135	10	135		785	47
48	Interior Design Fees	1998	3,000	300	10	300		1,745	48
49	Construction Project	1998	11,282	1,128	10	1,128		6,376	49
50	Painting & Staining	1998	13,725	1,373	10	1,373		7,756	50
51	Painting & Staining	1998	13,723	1,372	10	1,372		7,755	51
52	HVAC/Electrical Upgrade	1998	6,482	648	10	648		3,610	52
53	1998 Addition	1998	170,700	6,828	25	6,828		40,371	53
54	Wall & Door Install - Décor	1999	2,850	285	10	285		1,517	54
55	Architecture, Electrical	1998	10,602	1,060	10	1,060		5,644	55
56	Window Replacement	1998	4,765	476	10	476		2,536	56
57	Energy Study & Admin	1998	1,948	195	10	195		1,037	57
58	HVAC & Admin	1998	3,325	332	10	332		1,770	58
59	Carpet Installation	1999	125,765	12,577	10	12,577		65,880	59
60	MDC Wallcovering	1998	4,400	440	10	440		2,305	60
61	Add-Ons for Lobby Window	1999	1,800	180	10	180		943	61
62	Install Wood Veener	1999	894	89	10	89		468	62
63	Paint Sprinkler Pipes	1999	120	12	10	12		63	63
64	Air Conditioning	1999	446	18	25	18		91	64
65	Glass repair - bldg décor project	1999	2,659	266	10	266		1,327	65
66	Remodel 6 resident rooms	1999	720	72	10	72		359	66
67	120L/F/Roppe & Johnson	1999	170	17	10	17		84	67
68	Installation of Awnings	1999	8,307	831	10	831		3,865	68
69	Couch Wallcovering	1999	61	6	10	6		27	69
70	TOTAL (lines 4 thru 69)		$ 4,876,983	$ 143,027		$ 143,027	$	$ 3,903,161	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,876,983	$ 143,027		$ 143,027	$	$ 3,903,161	1
2	Installation of Awnings	2000	241	24	10	24		106	2
3	Installation of new windows	2000	35,200	3,520	10	3,520		15,216	3
4	Electric Upgrade	2000	16,253	1,625	10	1,625		9,529	4
5	2000 Addition	2000	49,564	4,956	10	4,956		20,178	5
6	Door to laundry	2000	5,995	600	10	600		2,391	6
7	Furniture & Flooring	2001	341,679	34,168	10	34,168		136,300	7
8	Cable tv system	2001	15,169	1,517	10	1,517		6,051	8
9	Awning Installation	2001	235,000	23,500	10	23,500		93,744	9
10	Exahust Fans Replacement	2001	6,055	606	10	606		2,415	10
11	Air Conditioning Project	2001	88	4	25	4		14	11
12	Air Conditioning project	2001	107,325	4,293	25	4,293		17,152	12
13	Air Conditioning project	2001	253,678	10,147	25	10,147		40,540	13
14	Signs Internally V Shaped	2001	20,570	2,057	10	2,057		8,206	14
15	Air Conditioning project	2001	147,096	5,884	25	5,884		22,508	15
16	Installation of private Cable System	2001	15,170	1,517	10	1,517		5,794	16
17	Seal Coating- St	2001	5,150	206	25	206		788	17
18	Boiler Set Up	2001	214,651	8,586	25	8,586		32,845	18
19	Facility Upgrades	2001	1,509	151	10	151		564	19
20	Facility Upgrades	2001	774	77	10	77		289	20
21	St Matts Air Conditioning	2001	78,348	3,134	25	3,134		11,465	21
22	Windows & Screen Replacement	2001	1,683	168	10	168		601	22
23	Facility Upgrades Cable	2001	5,467	547	10	547		1,952	23
24	Air Conditioning Project	2001	4,715	189	25	189		658	24
25	Air Conditioning Project	2001	11,400	456	25	456		1,553	25
26	Garbage Disposers	2001	3,512	351	10	351		1,138	26
27	Install chilled water cooler	2001	103,301	4,132	25	4,132		12,717	27
28	Fix Door and Wall	2001	3,280	131	25	131		535	28
29	Update Fire Panel	2000	7,051	705	10	705		2,166	29
30	Valve Project	2001	3,370	135	25	135		404	30
31	Counter Tops	2001	43,338	4,334	10	4,334		12,592	31
32	Windows & Screen	2001	1,683	168	10	168		489	32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,615,298	$ 260,915		$ 260,915	$	$ 4,364,061	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,615,298	$ 260,915		$ 260,915	$	$ 4,364,061	1
2	Tree Removal	2001	2,550	255	10	255		656	2
3	Facility Upgrade	2002	37,600	3,760	10	3,760		9,033	3
4	Facility Upgrade	2002	75,200	7,520	10	7,520		15,588	4
5	Tuckpointing	2003	8,555	856	10	856		1,035	5
6	Masonry Restoration	2003	47,520	4,752	10	4,752		4,956	6
7	Parking Lot Improvements	2003	7,725	773	10	773		806	7
8	FY 89 IDPA Audit - Phone System Amplifiers	1989	491		5			491	8
9	FY 89 IDPA Audit - Garbage Disposer	1989	2,654		5			2,654	9
10	FY 89 IDPA Audit - Ceiling Fans	1989	2,724		7			2,724	10
11	FY 89 IDPA Audit - Toilet Frames	1989	734		5			734	11
12	FY 89 IDPA Audit - Air Conditioner	1989	993		5			993	12
13	LANDSCAPING PHASE 1	2003	10,780	1,036	10	1,036		1,036	13
14	LANDSCAPING PHASE 1	2003	10,780	1,036	10	1,036		1,036	14
15	WINDOW REPAIRS	2003	2,450	235	10	235		235	15
16									16
17	COURT YARD CONCRETE REPAIRS	2004	7,676	32	10	32		32	17
18	WINDOW REPAIRS FROM BUILDING SHIFTING	2004	7,160	29	10	29		29	18
19	WINDOW REPLACEMENT	2004	5,648	23	10	23		23	19
20	REMODELING OF MAIN & SMALL DINING ROOM	2004	52,000	85	25	85		85	20
21	REMODELING OF MAIN & SMALL DINING ROOMS	2004	3,804	6	25	6		6	21
22									22
23									23
24									24
25									25
26	Management Assets - Security System	1999	42,908		10	658	658	N / A	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,945,250	$ 281,313		$ 281,971	$ 658	$ 4,406,213	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 888,364	$ 55,886	$ 101,588	$ 45,702	Various	$ 314,827	71
72	Current Year Purchases	368,736	48,848	50,202	1,354	Various	50,202	72
73	Fully Depreciated Assets	396,729				Various	396,729	73
74								74
75	TOTALS	$ 1,653,829	$ 104,734	$ 151,790	$ 47,056		$ 761,758	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transp.	1997 Champion Challenger	1997	$ 54,610	$ 7,801	$ 7,801	$	7	$ 52,498	76
77										77
78										78
79										79
80	TOTALS			$ 54,610	$ 7,801	$ 7,801	$		$ 52,498	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,692,393	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 393,848	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 441,562	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 47,714	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,220,469	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1990 Ford Paratransit Van	$ 36,850	$	$ 36,850	86
87	Pickup Truck	25,994	2,318	2,318	87
88					88
89	Management Autos	1,802	274	N/A	89
90					90
91	TOTALS	$ 64,646	$ 2,592	$ 39,168	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 27,440 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	N / A			
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	N / A
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs	N / A						7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St. Matthew Center for Health # 0013896 **Report Period Beginning:** 07/01/2003 **Ending:** 06/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N / A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N / A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note:
Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other assets, and most liabilities in a complex, multi-funtional service agency. Any balance sheet prepared with only those assets, liabilities and fund balances identifiable with specific programs would not balance or ptresent a meaningful picture of that program's financial status.

*** This must agree with page 17, line 47.**

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,823,883	1
2	Discounts and Allowances for all Levels	(311,195)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,512,688	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,800	13
14	Non-Patient Meals	1,732	14
15	Telephone, Television and Radio	2,894	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,426	23
	D. Non-Operating Revenue		
24	Contributions	27,167	24
25	Interest and Other Investment Income***	11	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27,178	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Cookie Sales	267	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,546,559	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,306,464	31
32	Health Care	4,011,556	32
33	General Administration	2,416,063	33
	B. Capital Expense		
34	Ownership	623,098	34
	C. Ancillary Expense		
35	Special Cost Centers	96,361	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,453,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	(906,983)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (906,983)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N / A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,698	1,980	$ 68,721	$ 34.71	1
2	Assistant Director of Nursing	10,210	11,198	121,373	10.84	2
3	Registered Nurses	42,607	46,657	1,134,364	24.31	3
4	Licensed Practical Nurses	36,058	40,640	520,632	12.81	4
5	Nurse Aides & Orderlies	70,935	77,969	844,126	10.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,861	2,094	24,893	11.89	8
9	Activity Director	4,390	4,767	78,115	16.39	9
10	Activity Assistants					10
11	Social Service Workers	3,985	4,484	73,661	16.43	11
12	Dietician					12
13	Food Service Supervisor	3,808	4,472	57,479	12.85	13
14	Head Cook	4,833	5,331	48,938	9.18	14
15	Cook Helpers/Assistants	25,740	28,193	215,436	7.64	15
16	Dishwashers					16
17	Maintenance Workers	6,562	7,047	109,637	15.56	17
18	Housekeepers	12,491	13,734	106,084	7.72	18
19	Laundry	5,390	5,834	52,676	9.03	19
20	Administrator	1,684	1,872	61,096	32.64	20
21	Assistant Administrator					21
22	Other Administrative	1,782	2,045	48,627	23.78	22
23	Office Manager					23
24	Clerical	8,767	9,526	133,899	14.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,919	7,595	84,873	11.17	31
32	Other Health Care(specify)					32
33	Other(specify)	3,110	3,666	76,864	20.97	33
34	TOTAL (lines 1 - 33)	252,830	279,104	$ 3,861,492 *	$ 13.84	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 93,702	1,3	35
36	Medical Director	As Needed	16,500	9,3	36
37	Medical Records Consultant	As Needed	4,472	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	1,936	10,3	39
40	Physical Therapy Consultant	As Needed	264,917	10a,3	40
41	Occupational Therapy Consultant	As Needed	241,107	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	105,660	10a,3	43
44	Activity Consultant	As Needed	6,975	10a,3	44
45	Social Service Consultant				45
46	Other(specify)	As Needed	31,990	Various	46
47	Legal & Audit Accounting	As Needed	32,566	19,3	47
48	Laundry Services	As Needed	71,086	4,3	48
49	TOTAL (lines 35 - 48)		$ 870,911		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gerrianne Dathe			$ 61,096
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,096

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Duane, Morris & Heckscher	Legal Fees	$ 325
Frost Ruttenberg and Roth	Audit & Accounting	24,785
Office Team	Medicare consultation/report se	622
Revere Health Care	Acct/bookkeeping Temp	4,150
Accountemps	Acct/bookkeeping Temp	2,683
LSSI	Management Services	682,046
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 714,611

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 188,872
Unemployment Compensation Insurance	19,906
FICA Taxes	277,270
Employee Health Insurance	354,666
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	133,534
Management Allocation Benfits	71,885
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,046,133

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Awards and Grants	32,751
Subscriptions & Books	1,046
Membership Dues	6,384
Management Allocation	4,301
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,482

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Vehicle Operating Cost	1,126
Employee Milage Payment	2,143
Meals, Lodging	337
Seminar Expense	2,814
Conference & Convention	1,248
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,668

**See instructions.

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N / A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St. Matthew Center for Health # 0013896 Report Period Beginning: 07/01/2003 Ending: 06/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $6384**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **38,885** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **96,361**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,732**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/ A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **In Progress, will send as soon as availa**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.